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12VAC30-120-700
Part VIII
Individual and Family Developmental Disabilities Support Waiver Regulations

Article 1
General Requirements

12VAC30-120-700. Definitions.

"Activities of daily living" or "ADL" means personal care tasks, e.g., bathing, dressing, toileting, transferring, and eating/feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and services.

"Appeal" means the process used to challenge adverse actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110, Eligibility and Appeals, and 12VAC30-20-500 through 12VAC30-20-560.

"Assistive technology" means specialized medical equipment and supplies including those devices, controls, or appliances specified in the plan of care but not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or that are necessary to the proper functioning of the specialized equipment.

"Behavioral health authority" or "BHA" means the local agency, established by a city or county or a combination of counties or cities or cities and counties under Chapter 6 (§ 37.2-600 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, intellectual disability, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Case management" means services as defined in 12VAC30-50-490.

"Case manager" means the provider of case management services as defined in 12VAC30-50-490.

"Centers for Medicare and Medicaid Services" or "CMS" means the unit of the federal Department of Health and Human Services that administers the Medicare and Medicaid programs.

"Community-based waiver services" or "waiver services" means a variety of home and community-based services paid for by DMAS as authorized under a § 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/IID placement.

"Community services board" or "CSB" means the local agency, established by a city or county or combination of counties or cities, or cities and counties, under Chapter 5 (§ 37.2-500 et seq.) of Title 37.2 of the Code of Virginia, that plans, provides, and evaluates mental health, intellectual disability, and substance abuse services in the jurisdiction or jurisdictions it serves.

"Companion" means, for the purpose of these regulations, a person who provides companion services.

"Companion services" means nonmedical care, supervision, and socialization provided to an adult (age 18 years or older). The provision of companion services does not entail hands-on care. It is provided in accordance with a therapeutic goal in the plan of care and is not purely diversional in nature.

"Consumer-directed employee" means, for purposes of these regulations, a person who provides consumer-directed services, personal care, companion services, or respite care, who is also exempt from workers' compensation.

"Consumer-directed services" means personal care, companion services, or respite care services where the individual or his family/caregiver, as appropriate, is responsible for hiring, training, supervising, and firing of the employee or employees.

"Consumer-directed (CD) services facilitator" means the provider enrolled with DMAS who is responsible for management training and review activities as required by DMAS for consumer-directed services.

"Crisis stabilization" means direct intervention for persons with related conditions who are experiencing serious psychiatric or behavioral challenges, or both, that jeopardize their current community living situation. This service must provide temporary intensive services and supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement. This service shall be designed to stabilize individuals and strengthen the current living situations so that individuals may be maintained in the community during and beyond the crisis period.

"Current functional status" means an individual's degree of dependency in performing activities of daily living.

"DARS" means the Department for Aging and Rehabilitative Services.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DBHDS staff" means employees of DBHDS who provide technical assistance and review individual level of care criteria.

"DMAS" means the Department of Medical Assistance Services.

"DMAS staff" means DMAS employees who perform utilization review, preauthorize service type and intensity, and provide technical assistance.

"DSS" means the Department of Social Services.

"Day support" means training in intellectual, sensory, motor, and affective social development including awareness skills, sensory stimulation, use of appropriate behaviors and social skills, learning and problem solving, communication and self care, physical development, services and support activities. These services take place outside of the individual's home/residence.

"Direct marketing" means either (i) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (ii) mailing directly; (iii) paying "finders' fees"; (iv) offering financial incentives, rewards, gifts, or special opportunities to eligible individuals or family/caregivers as inducements to use the providers' services; (v) continuous, periodic marketing activities to the same prospective individual or his family/caregiver, as appropriate, for example, monthly, quarterly, or annual giveaways as inducements to use the providers' services; or (vi) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of the providers' services or other benefits as a means of influencing the individual's or his family/caregiver's, as appropriate, use of the providers' services.

"Enroll" means that the individual has been determined by the IFDDS screening team to meet the eligibility requirements for the waiver, DBHDS has approved the individual's plan of care and has assigned an available slot to the individual, and DSS has determined the individual's Medicaid eligibility for home and community-based services.

"Entrepreneurial model" means a small business employing eight or fewer individuals with disabilities on a shift and may involve interactions with the public and coworkers with disabilities.

"Environmental modifications" means physical adaptations to a house, place of residence, primary vehicle or work site, when the work site modification exceeds reasonable accommodation requirements of the Americans with Disabilities Act, necessary to ensure individuals' health and safety or enable functioning with greater independence when the adaptation is not being used to bring a substandard dwelling up to minimum habitation standards and is of direct medical or remedial benefit to individuals.

"EPSDT" means the Early Periodic Screening, Diagnosis and Treatment program administered by DMAS for children under the age of 21 years according to federal guidelines that prescribe specific preventive and treatment services for Medicaid-eligible children as defined in 12VAC30-50-130.

"Face-to-face visit" means the case manager or service provider must meet with the individual in person and that the individual should be engaged in the visit to the maximum extent possible.

"Family/caregiver training" means training and counseling services provided to families or caregivers of individuals receiving services in the IFDDS Waiver.

"Fiscal agent" means an entity handling employment, payroll, and tax responsibilities on behalf of individuals who are receiving consumer-directed services.

"Home" means, for purposes of the IFDDS Waiver, an apartment or single family dwelling in which no more than four individuals who require services live, with the exception of siblings living in the same dwelling with family. This does not include an assisted living facility or group home.

"Home and community-based waiver services" means a variety of home and community-based services reimbursed by DMAS as authorized under a § 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid ICF/IID placement.

"ICF/IID" means a facility or distinct part of a facility certified as meeting the federal certification regulations for an Intermediate Care Facility for Individuals with Intellectual Disabilities and persons with related conditions. These facilities must address the residents' total needs including physical, intellectual, social, emotional, and habilitation. An ICF/IID must provide active treatment, as that term is defined in 42 CFR 483.440(a).

"IDEA" means the federal Individuals with Disabilities Education Act of 2004, 20 USC § 1400 et seq.

"ID Waiver" means the Intellectual Disability waiver.

"IFDDS screening team" means the persons employed by the entity under contract with DMAS who are responsible for performing level of care screenings for the IFDDS Waiver.

"IFDDS Waiver," "IFDDS," or "DD" means the Individual and Family Developmental Disabilities Support Waiver.

"In-home residential support services" means support provided primarily in the individual's home, which includes training, assistance, and specialized supervision to enable the individual to maintain or improve his health; assisting in performing individual care tasks; training in activities of daily living; training and use of community resources; providing life skills training; and adapting behavior to community and home-like environments.

"Instrumental activities of daily living" or "IADL" means meal preparation, shopping, housekeeping, laundry, and money management.

"Intellectual disability" or "ID" means a disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD) in the Intellectual Disability: Definition, Classification, and Systems of Supports (11th edition, 2010).

"Participating provider" means an entity that meets the standards and requirements set forth by DMAS and has a current, signed provider participation agreement with DMAS.

"Pend" means delaying the consideration of an individual's request for authorization of services until all required information is received by DMAS or by its authorized agent.

"Person-centered planning" means a process, directed by the individual or his family/caregiver, as appropriate, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the individual.

"Personal care provider" means a participating provider that renders services to prevent or reduce inappropriate institutional care by providing eligible individuals with personal care aides to provide personal care services.

"Personal care services" means long-term maintenance or support services necessary to enable individuals to remain in or return to the community rather than enter an Intermediate Care Facility for Individuals with Intellectual Disabilities. Personal care services include assistance with activities of daily living, instrumental activities of daily living, access to the community, medication or other medical needs, and monitoring health status and physical condition. This does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

"Personal emergency response system" or "PERS" is an electronic device that enables certain individuals to secure help in an emergency. PERS services are limited to those individuals who live alone or are alone for

significant parts of the day and who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

"Plan of care" means a document developed by the individual or his family/caregiver, as appropriate, and the individual's case manager addressing all needs of individuals of home and community-based waiver services, in all life areas. Supporting documentation developed by waiver service providers is to be incorporated in the plan of care by the case manager. Factors to be considered when these plans are developed must include, but are not limited to, individuals' ages, levels of functioning, and preferences.

"Preauthorized" means the service authorization agent has approved a service for initiation and reimbursement of the service by the service provider.

"Primary caregiver" means the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for such care.

"Qualified developmental disabilities professional" or "QDDP" means a professional who (i) possesses at least one year of documented experience working directly with individuals who have related conditions; (ii) is one of the following: a doctor of medicine or osteopathy, a registered nurse, a provider holding at least a bachelor's degree in a human service field including, but not limited to, sociology, social work, special education, rehabilitation engineering, counseling or psychology, or a provider who has documented equivalent qualifications; and (iii) possesses the required Virginia or national license, registration, or certification in accordance with his profession, if applicable.

"Related conditions" means those persons who have autism or who have a severe chronic disability that meets all of the following conditions identified in 42 CFR 435.1009:

1. It is attributable to:

a. Cerebral palsy or epilepsy; or

b. Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability, and requires treatment or services similar to those required for these persons.

2. It is manifested before the person reaches age 22 years.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self-care.

b. Understanding and use of language.

c. Learning.

d. Mobility.

e. Self-direction.

f. Capacity for independent living.

"Respite care" means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves and are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

"Respite care provider" means a participating provider that renders services designed to prevent or reduce inappropriate institutional care by providing respite care services for unpaid caregivers of eligible individuals.

"Screening" means the process conducted by the IFDDS screening team to evaluate the medical, nursing, and social needs of individuals referred for screening and to determine eligibility for an ICF/IID level of care.

"Skilled nursing services" means nursing services (i) listed in the plan of care that do not meet home health criteria, (ii) required to prevent institutionalization, (iii) not otherwise available under the State Plan for Medical Assistance, (iv) provided within the scope of the state's Nursing Act (§ 54.1-3000 et seq. of the Code of Virginia) and Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia), and (v) provided by a registered professional nurse or by a licensed practical nurse under the supervision of a registered nurse who is licensed to practice in the state. Skilled nursing services are to be used to provide training, consultation, nurse delegation as appropriate, and oversight of direct care staff as appropriate.

"Slot" means an opening or vacancy of waiver services for an individual.

"Specialized supervision" means staff presence necessary for ongoing or intermittent intervention to ensure an individual's health and safety.

"State Plan for Medical Assistance" or "the State Plan" means the document containing the covered groups, covered services and their limitations, and provider reimbursement methodologies as provided for under Title XIX of the Social Security Act.

"Supporting documentation" means the specific plan of care developed by the individual and waiver service provider related solely to the specific tasks required of that service provider. Supporting documentation helps to comprise the overall plan of care for the individual, developed by the case manager and the individual.

"Supported employment" means work in settings in which persons without disabilities are typically employed. It includes training in specific skills related to paid employment and provision of ongoing or intermittent assistance and specialized supervision to enable an individual to maintain paid employment.

"Therapeutic consultation" means consultation provided by members of psychology, social work, rehabilitation engineering, behavioral analysis, speech therapy, occupational therapy, psychiatry, psychiatric clinical nursing, therapeutic recreation, or physical therapy or behavior consultation to assist individuals, parents, family members, in-home residential support, day support, and any other providers of support services in implementing a plan of care.

"Transition services" means set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. 12VAC30-120-2010 provides the service description, criteria, service units and limitations, and provider requirements for this service.

"VDH" means the Virginia Department of Health.

12VAC30-120-710
12VAC30-120-710. General coverage and requirements for all home and community-based waiver services.

A. Waiver service populations. Home and community-based services shall be available through a § 1915(c) waiver. Coverage shall be provided under the waiver for individuals six years of age or older with related conditions as defined in 12VAC30-120-700, including autism, who have been determined to require the level of care provided in an ICF/IID. The individual must not have a diagnosis of intellectual disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD). Intellectual Disability Waiver recipients who are six years of age on or after October 1, 2002, who are determined to not have a diagnosis of intellectual disability, and who meet all IFDDS Waiver eligibility criteria, shall be eligible for and shall transfer to the IFDDS Waiver effective with their sixth birthday. Psychological evaluations confirming diagnoses must be completed less than one year prior to the child's sixth birthday. These recipients transferring from the ID Waiver will automatically be assigned a slot in the IFDDS Waiver. Such slot shall be in addition to those slots available through the screening process described in 12VAC30-120-720 B and C.

B. Covered services.

1. Covered services shall include in-home residential supports, day support, prevocational services, supported employment, personal care (both agency-directed and consumer-directed), respite care (both agency-directed and consumer-directed), assistive technology, environmental modifications, skilled nursing services, therapeutic consultation, crisis stabilization, personal emergency response systems (PERS), family/caregiver training, companion services (both agency-directed and consumer-directed), and transition services.

2. These services shall be appropriate and medically necessary to maintain these individuals in the community. Federal waiver requirements provide that the average per capita fiscal year expenditures under the waiver must not exceed the average per capita expenditures for the level of care provided in ICFs/IID under the State Plan that would have been made had the waiver not been granted.

3. Under this § 1915(c) waiver, DMAS waives subdivision (a)(10)(B) of § 1902 of the Social Security Act related to comparability.

C. Eligibility criteria for emergency access to the waiver.

1. Subject to available funding and a finding of eligibility under 12VAC30-120-720, individuals must meet at least one of the emergency criteria of this subdivision to be eligible for immediate access to waiver services without consideration to the length of time an individual has been waiting to access services. In the absence of waiver services, the individual would not be able to remain in his home. The criteria are as follows:

a. The primary caregiver has a serious illness, has been hospitalized, or has died;

b. The individual has been determined by the DSS to have been abused or neglected and is in need of immediate waiver services;

c. The individual demonstrates behaviors that present risk to personal or public safety;

d. The individual presents extreme physical, emotional, or financial burden at home, and the family or caregiver is unable to continue to provide care; or

e. The individual lives in an institutional setting and has a viable discharge plan in place.

2. When emergency slots become available:

a. All individuals who have been found eligible for the IFDDS Waiver but have not been enrolled shall be notified by either DBHDS or the individual's case manager.

b. Individuals and their family/caregivers shall be given 30 calendar days to request emergency consideration.

c. An interdisciplinary team of DBHDS professionals shall evaluate the requests for emergency consideration within 10 calendar days from the 30-calendar day deadline using the emergency criteria to determine who will be assigned an emergency slot. If DBHDS receives more requests than the number of available emergency slots, then the interdisciplinary team will make a decision on slot allocation based on need as documented in the request for emergency consideration. A waiting list of emergency cases will not be kept.

D. Appeals. Individual appeals shall be considered pursuant to 12VAC30-110-10 through 12VAC30-110-370. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

12VAC30-120-720
12VAC30-120-720. Qualification and eligibility requirements; intake process.

A. Individuals receiving services under this waiver must meet the following requirements. Virginia will apply the financial eligibility criteria contained in the State Plan for the categorically needy. Virginia has elected to cover the optional categorically needy groups under 42 CFR 435.121 and 435.217. The income level used for 42 CFR 435.121 and 435.217 is 300% of the current Supplemental Security Income payment standard for one person.

1. Under this waiver, the coverage groups authorized under § 1902(a)(10)(A)(ii)(VI) of the Social Security Act will be considered as if they were institutionalized for the purpose of applying institutional deeming rules. All individuals under the waiver must meet the financial and nonfinancial Medicaid eligibility criteria and meet the institutional level of care criteria. The deeming rules are applied to waiver eligible individuals as if the individual were residing in an institution or would require that level of care.

2. Virginia shall reduce its payment for home and community-based waiver services provided to an individual who is eligible for Medicaid services under 42 CFR 435.217 by that amount of the individual's total income (including amounts disregarded in determining eligibility) that remains after allowable deductions for personal maintenance needs, deductions for other dependents, and medical needs have been made, according to the

guidelines in 42 CFR 435.735 and § 1915(c)(3) of the Social Security Act as amended by the Consolidated Omnibus Budget Reconciliation Act of 1986. DMAS will reduce its payment for home and community-based waiver services by the amount that remains after the following deductions:

a. For individuals to whom § 1924(d) applies, and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a spouse at home, the community spousal income allowance determined in accordance with § 1924(d) of the Social Security Act.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family determined in accordance with § 1924(d) of the Social Security Act.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Plan.

b. For individuals to whom § 1924(d) does not apply and for whom Virginia waives the requirement for comparability pursuant to § 1902(a)(10)(B), deduct the following in the respective order:

(1) The basic maintenance needs for an individual, which is equal to 165% of the SSI payment for one person. Due to expenses of employment, a working individual shall have an additional income allowance. For an individual employed 20 hours or more per week, earned income shall be disregarded up to a maximum of 300% SSI; for an individual employed at least eight but less than 20 hours per week, earned income shall be disregarded up to a maximum of 200% of SSI. If the individual requires a guardian or conservator who charges a fee, the fee, not to exceed an amount greater than 5.0% of the individual's total monthly income, is added to the maintenance needs allowance. However, in no case shall the total amount of the maintenance needs allowance (basic allowance plus earned income allowance plus guardianship fees) for the individual exceed 300% of SSI.

(2) For an individual with a dependent child or children, an additional amount for the maintenance needs of the child or children, which shall be equal to the Title XIX medically needy income standard based on the number of dependent children.

(3) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including Medicare and other health insurance premiums, deductibles, or coinsurance charges and necessary medical or remedial care recognized under state law but not covered under the State Medical Assistance Plan.

B. Screening.

1. To ensure that Virginia's home and community-based waiver programs serve only individuals who would otherwise be placed in an ICF/IID, home and community-based waiver services shall be considered only for individuals who are eligible for admission to an ICF/IID, absent a diagnosis of intellectual disability and are age six years or older. Home and community-based waiver services shall be the critical service that enables the individual to remain at home rather than being placed in an ICF/IID.

2. To be eligible for IFDDS Waiver services, the individual must:

a. Be determined to be eligible for the ICF/IID level of care;

b. Be six years of age or older;

c. Meet the related conditions definition as defined in 42 CFR 435.1009 or be diagnosed with autism; and

d. Not have a diagnosis of intellectual disability as defined by the American Association on Intellectual and Developmental Disabilities (AAIDD).

3. A child younger than six years of age shall not be screened until three months prior to the month of their sixth birthday. A child younger than six years of age shall not be added to the waiver or the wait list until the month in which the child's sixth birthday occurs.

4. The IFDDS screening team shall gather relevant medical and social data and identify all services received by and supports available to the individual. The IFDDS screening team shall also gather psychological evaluations or refer the individual to a private or publicly funded psychologist for evaluation of the cognitive abilities of each screening applicant.

5. The individual's status as an individual in need of IFDDS home and community-based care waiver services shall be determined by the IFDDS screening team after completion of a thorough assessment of the individual's needs and available supports. Screening for home and community-based care waiver services by the IFDDS screening team or DBHDS staff is mandatory before Medicaid will assume payment responsibility of home and community-based care waiver services.

6. The IFDDS screening team determines the level of care by applying existing DMAS ICF/IID criteria (12VAC30-130-430).

7. The IFDDS screening team shall explore alternative settings and services to provide the care needed by the individual with the individual and his family/caregiver, as appropriate. If placement in an ICF/IID or a combination of other services is determined to be appropriate, the IFDDS screening team shall initiate a referral for service to DBHDS. If Medicaid-funded home and community-based waiver services are determined to be the critical service to delay or avoid placement in an ICF/IID or promote exiting from an institutional setting, the IFDDS screening team shall initiate a referral for service to a case manager of the individual's choice. Referrals are based on the individual choosing either ICF/IID placement or home and community-based waiver services.

8. Home and community-based waiver services shall not be provided to any individual who resides in a nursing facility, an ICF/IID, a hospital, an adult family care home approved by the DSS, a group home licensed by DBHDS, or an assisted living facility licensed by the DSS. However, an individual may be screened for the IFDDS Waiver and placed on the wait list while residing in one of the aforementioned facilities.

9. The IFDDS screening team must submit the results of the comprehensive assessment and a recommendation to DBHDS staff for final determination of ICF/IID level of care and authorization for home and community-based waiver services.

10. For children receiving ID Waiver services prior to age six to transfer to the IFDDS Waiver during their sixth year, the individual's ID Waiver case manager shall submit to DBHDS the child's most recent Level of Functioning form, the plan of care, and a psychological examination completed no more than one year prior to transferring. Such documentation must demonstrate that no diagnosis of intellectual disability exists in order for this transfer to the IFDDS Waiver to be approved. The case manager shall be responsible for notifying DBHDS and DSS, via the DMAS-225, when a child transfers from the ID Waiver to the IFDDS Waiver. Transfers must be completed prior to the child's seventh birthday.

C. Waiver approval process: available funding.

1. In order to ensure cost effectiveness of the IFDDS Waiver, the funding available for the waiver is allocated between two budget levels. The budget is the cost of waiver services only and does not include the costs of other Medicaid covered services. Other Medicaid services, however, must be counted toward cost effectiveness of the IFDDS Waiver. All services available under the waiver are available to both levels.

2. Level one is for individuals whose comprehensive plans of care cost less than $25,000 per fiscal year. Level two is for individuals whose plans of care costs are equal to or more than $25,000. There is no threshold for budget level two; however, if the actual cost of waiver services exceeds the average annual cost of ICF/IID care for an individual, the individual's care is case managed by DBHDS staff.

3. Fifty percent of available waiver funds are allocated to budget level one, and 40% of available waiver funds are allocated to level two in order to ensure that the waiver is cost effective. The remaining 10% of available

waiver funds is allocated for emergencies as defined in 12VAC30-120-710. In order to transition an appropriate number of level one slots to emergency slots, every third level one slot that becomes available will convert to an emergency slot until the percentage of emergency slots reaches 10%. Half of emergency slots will be allocated for individuals in institutional settings who are discharge ready and have a viable discharge plan to transition into the community within 60 days. If there are no such individuals who choose to discharge into the community when emergency slots are available for institutionalized individuals, the emergency slot will be allocated to an individual residing in the community who meets emergency criteria.

D. Assessment and enrollment.

1. The IFDDS screening team shall determine if an individual meets the functional criteria within 45 calendar days of receiving the request for screening from the individual or his family/caregiver, as appropriate. Once the IFDDS screening team determines that an individual meets the eligibility criteria for IFDDS Waiver services and the individual has chosen this service, the IFDDS screening team shall provide the individual with a list of available case managers. The individual or his family/caregiver, as appropriate, shall choose a case manager within 10 calendar days of receiving the list of case managers and the IFDDS screening team shall forward the screening materials within 10 calendar days of the case manager's selection to the selected case manager.

2. The case manager shall contact the individual within 10 calendar days of receipt of screening materials. The case manager must meet face-to-face with the individual and his family/caregiver, as appropriate, within 30 calendar days to discuss the individual's needs, existing supports and to develop a preliminary plan of care identifying needed services and estimating the annual waiver cost of the individual's plan of care. If the individual's annual waiver services cost is expected to exceed the average annual cost of ICF/IID care for an individual, the individual's case management shall be provided by DBHDS.

3. Once the plan of care has been initially developed, the case manager shall contact DBHDS to request approval of the plan of care and to enroll the individual in the IFDDS Waiver. DBHDS shall, within 14 calendar days of receiving all supporting documentation, either approve for Medicaid coverage or deny for Medicaid coverage the plan of care.

4. Medicaid will not pay for any home and community-based waiver services delivered prior to the authorization date approved by DMAS. Any plan of care for home and community-based waiver services must be pre-approved by DBHDS prior to Medicaid reimbursement for waiver services.

5. The following five criteria shall apply to all IFDDS Waiver services:

a. Individuals qualifying for IFDDS Waiver services must have a demonstrated clinical need for the service resulting in significant functional limitations in major life activities. In order to be eligible, an individual must be six years of age or older, have a related condition as defined in these regulations, cannot have a diagnosis of intellectual disability, and would, in the absence of waiver services, require the level of care provided in an ICF/IID facility, the cost of which would be reimbursed under the State Plan;

b. The plan of care and services that are delivered must be consistent with the Medicaid definition of each service;

c. Services must be approved by the case manager based on a current functional assessment tool approved by DBHDS or other DBHDS-approved assessment and demonstrated need for each specific service;

d. Individuals qualifying for IFDDS Waiver services must meet the ICF/IID level of care criteria; and

e. The individual must be eligible for Medicaid as determined by the local office of DSS.

6. DBHDS shall only authorize a waiver slot for the individual if a slot is available. If DBHDS does not have a waiver slot for this individual, the individual shall be placed on the waiting list until such time as a waiver slot becomes available for the individual.

7. DBHDS will notify the case manager when a slot is available for the individual. The case manager shall also notify the local DSS by submitting a DMAS-225 and IFDDS Level of Care Eligibility form. The case manager shall inform the individual so that the individual may apply for Medicaid if necessary and begin choosing waiver service providers for services listed in the plan of care.

8. The case manager forwards a copy of the completed DMAS-225 to DBHDS. Upon receipt of the completed DMAS-225, DBHDS shall enroll the individual into the IFDDS Waiver.

9. Once the individual has been determined to be Medicaid eligible and enrolled in the waiver, the individual or case manager shall contact the waiver service providers that the individual or his family/caregiver, as appropriate, chooses, who shall initiate waiver services within 60 calendar days. During this time, the individual, case manager, and waiver service providers shall meet to complete the provider's supporting documentation for the plan of care, implementing a person-centered planning process. The waiver service providers shall develop supporting documentation for each waiver service and shall submit a copy of this documentation to the case manager. If services are not initiated within 60 calendar days, the case manager must submit information to DBHDS demonstrating why more time is needed to initiate services and request in writing a 30-calendar-day extension, up to a maximum of four consecutive extensions, for the initiation of waiver services. DBHDS must receive the request for extension letter within the 30-calendar-day extension period being requested. DBHDS will review the request for extension and make a determination within 10 calendar days of receiving the request. DBHDS has authority to approve or deny the 30-calendar-day extension request.

10. The case manager shall monitor the waiver service providers' supporting documentation to ensure that all providers are working toward the identified goals of the individual. The case manager shall review and sign off on the supporting documentation. The case manager shall contact the preauthorization agent for service authorization of waiver services and shall notify the waiver service providers when waiver services are approved.

11. The case manager shall contact the individual at a minimum on a monthly basis and as needed to conduct case management activities as defined in 12VAC30-50-490. DBHDS shall conduct annual level of care reviews in which the individual is assessed to ensure continued waiver eligibility. DMAS DBHDS shall review individuals' plans of care and shall review the services provided by case managers and waiver service providers.

E. Reevaluation of service need and utilization review.

1. The plan of care.

a. The case manager shall develop the plan of care, implementing a person-centered planning process with the individual, his family/caregiver, as appropriate, other service providers, and other interested parties identified by the individual or family/caregiver, based on relevant, current assessment data. The plan of care development process determines the services to be provided for individuals, the frequency of services, the type of service provided, and a description of the services to be offered. All plans of care written by the case managers must be approved by DBHDS prior to seeking authorization for services. DMAS is the single state authority responsible for the supervision of the administration of the home and community-based waiver.

b. The case manager is responsible for continuous monitoring of the appropriateness of the individual's services by reviewing supporting documentation and revisions to the plan of care as indicated by the changing needs of the individual. At a minimum, every three months the case manager must:

(1) Review the plan of care face-to-face with the individual and family/caregiver, as appropriate, using a person-centered planning approach;

(2) Review individual provider quarterly reports to ensure goals and objectives are being met; and

(3) Determine whether any modifications to the plan of care are necessary, based upon the needs of the individual.

c. At least once per plan of care year this review must be performed with the individual present, and his family/caregivers as appropriate, in the individual's home environment.

d. DBHDS staff shall review the plan of care every 12 months or more frequently as required to assure proper utilization of services. Any modification to the amount or type of services in the plan of care must be approved by DBHDS.

2. Annual reassessment.

a. The case manager or DBHDS, if DBHDS is acting as the individual's case manager, shall complete an annual comprehensive reassessment, in coordination with the individual, family/caregiver, and service providers. If warranted, the case manager will coordinate a medical examination and a psychological evaluation for every waiver individual. The reassessment, completed in a person-centered planning manner, must include an update of the assessment instrument and any other appropriate assessment data.

b. A medical examination must be completed for adults 18 years of age and older based on need identified by the individual, his family/caregiver, as appropriate, providers, the case manager, or DBHDS staff. Medical examinations for children must be completed according to the recommended frequency and periodicity of the EPSDT program.

c. A psychological evaluation or standardized developmental assessment for children older than six years of age and adults must reflect the current psychological status (diagnosis), adaptive level of functioning, and cognitive abilities. A new psychological evaluation is required whenever the individual's functioning has undergone significant change and the current evaluation no longer reflects the individual's current psychological status.

3. Documentation required.

a. The case management provider must maintain the following documentation for review by the DBHDS staff for each waiver individual:

(1) All assessment summaries and all plans of care completed for the individual are maintained for a period of not less than six years;

(2) All supporting documentation from any provider rendering waiver services for the individual;

(3) All supporting documentation related to any change in the plan of care;

(4) All related communication with the individual, his family/caregiver, as appropriate, providers, consultants, DBHDS, DMAS, DSS, DARS, or other related parties;

(5) An ongoing log documenting all contacts related to the individual made by the case manager that relate to the individual;

(6) The individual's most recent, completed level of functioning;

(7) Psychologicals;

(8) Communications with DBHDS;

(9) Documentation of rejection or refusal of services and potential outcomes resulting from the refusal of services communicated to the individual; and

(10) DMAS-225.

b. The waiver service providers must maintain the following documentation for review by the DMAS or DBHDS staff for each waiver individual:

(1) All supporting documentation developed for that individual and maintained for a period of not less than six years;

(2) An attendance log documenting the date and times services were rendered and the amount and the type of services rendered;

(3) Appropriate progress notes reflecting the individual's status and, as appropriate, progress toward the identified goals on the supporting documentation;

(4) All communication relating to the individual. Any documentation or communication must be dated and signed by the provider;

(5) Service authorization decisions;

(6) Plans of care specific to the service being provided; and

(7) Assessments/reassessments as required for the service being provided.

12VAC30-120-730
12VAC30-120-730. General requirements for home and community-based participating providers.

A. Providers approved for participation shall, at a minimum, perform the following activities:

1. Immediately notify DMAS, in writing, of any change in the information that the provider previously submitted to DMAS.

2. Assure freedom of choice for individuals seeking services from any institution, pharmacy, practitioner, or other provider qualified to perform the service or services required and participating in the Medicaid Program at the time the service or services were performed.

3. Assure the individual's freedom to reject medical care, treatment, and services, and document that potential adverse outcomes that may result from refusal of services were discussed with the individual.

4. Accept referrals for services only when staff is available to initiate services within 30 calendar days and perform such services on an ongoing basis.

5. Provide services and supplies for individuals in full compliance with Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.), which prohibits discrimination on the grounds of race, color, or national origin; the Virginians with Disabilities Act (Title 51.5 (§ 51.5-1 et seq.) of the Code of Virginia); § 504 of the Rehabilitation Act of 1973, as amended (29 USC § 794), which prohibits discrimination on the basis of a disability; and the Americans with Disabilities Act, as amended (42 USC § 12101 et seq.), which provides comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services, and telecommunications.

6. Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public.

7. Submit charges to DMAS for the provision of services and supplies for individuals in amounts not to exceed the provider's usual and customary charges to the general public and accept as payment in full the amount established by DMAS from the individual's authorization date for waiver services.

8. Use program-designated billing forms for submission of charges.

9. Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the care provided.

a. Such records shall be retained for at least six years from the last date of service or as provided by applicable state and federal laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception resolved. Records of minors shall be kept for at least six years after such minor has reached the age of 18 years.

b. Policies regarding retention of records shall apply even if the provider discontinues operation. DMAS shall be notified in writing of storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

c. An attendance log or similar document must be maintained that indicates the date services were rendered, type of services rendered, and number of hours/units provided (including specific time frame).

10. Consistent with 12VAC30-120-1040, agree to furnish information on request and in the form requested to DMAS, DBHDS, the Attorney General of Virginia or his authorized representatives, federal personnel, and the State Medicaid Fraud Control Unit. The Commonwealth's right of access to provider premises and records shall survive any termination of the provider participation agreement.

11. Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals enrolled in Medicaid.

B. Pursuant to 42 CFR Part 431, Subpart F, 12VAC30-20-90, and any other applicable federal or state law, all providers shall hold confidential and use for DMAS or DBHDS authorized purposes only all medical assistance

information regarding individuals served. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS in conjunction with the cited laws. DMAS shall not disclose medical information to the public.

C. Change of ownership. When ownership of the provider changes, the provider must notify DMAS at least 15 calendar days before the date of change.

D. For (ICF/IID) facilities covered by § 1616(e) of the Social Security Act in which respite care as a home and community-based waiver service will be provided, the facilities shall be in compliance with applicable standards that meet the requirements for board and care facilities. Health and safety standards shall be monitored through the DBHDS' licensure standards or through DSS-approved standards for adult foster care providers.

E. Suspected abuse or neglect. Pursuant to §§ 63.2-1509 and 63.2-1606 of the Code of Virginia, if a participating provider knows or suspects that a home and community-based waiver service individual is being abused, neglected, or exploited, the party having knowledge or suspicion of the abuse, neglect, or exploitation shall report this immediately from first knowledge to the local DARS adult or DSS child protective services agency, as applicable, as well as to DMAS, and, if applicable, to DBHDS Offices of Licensing and Human Rights.

F. Adherence to provider participation agreement and the DMAS provider manual. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their individual provider participation agreements and in the DMAS provider manual.

G. DMAS may terminate the provider's Medicaid provider agreement pursuant to § 32.1-325 of the Code of Virginia and as may be required for federal financial participation. Such provider agreement terminations shall conform to 12VAC30-10-690 and Part XII (12VAC30-20-500 et seq.) of 12VAC30-20. DMAS shall not reimburse for services that may be rendered subsequent to such terminations.

H. Direct marketing. Providers are prohibited from performing any type of direct marketing activities to Medicaid individuals or their family/caregivers.

12VAC30-120-740
12VAC30-120-740. Participation standards for home and community-based waiver services participating providers.

A. Requests for participation. Requests will be screened to determine whether the provider applicant meets the basic requirements for participation.

B. Provider participation standards. For DMAS to approve provider participation agreements with home and community-based waiver providers, the following standards shall be met:

1. For services that have licensure and certification requirements, licensure and certification requirements pursuant to 42 CFR 441.352.

2. Disclosure of ownership pursuant to 42 CFR 455.104 and 455.105.

3. The ability to document and maintain individual case records in accordance with state and federal requirements.

C. Adherence to provider participation agreements and special participation conditions. In addition to compliance with the general conditions and requirements, all providers enrolled by DMAS shall adhere to the conditions of participation outlined in their provider participation agreements.

D. Individual choice of provider entities. The individual will have the option of selecting the provider of his choice. The case manager must inform the individual of all available waiver service providers in the community in which he desires services, and he shall have the option of selecting the provider of his choice.

E. Review of provider participation standards and renewal of provider participation agreements. DMAS is responsible for assuring continued adherence to provider participation standards. DMAS shall conduct ongoing monitoring of compliance with provider participation standards and DMAS policies and recertify each provider for agreement renewal with DMAS to provide home and community-based waiver services. A provider's noncompliance with DMAS policies and procedures, as required in the provider's participation agreement, may

result in a written request from DMAS for a corrective action plan that details the steps the provider must take and the length of time permitted to achieve full compliance with the plan to correct the deficiencies that have been cited.

F. Termination of provider participation. A participating provider may voluntarily terminate his participation in Medicaid by providing 30 calendar days' written notification. DMAS may terminate at will a provider's participation agreement on 30 calendar days' written notice as specified in the DMAS participation agreement. DMAS may also immediately terminate a provider's participation agreement if the provider is no longer eligible to participate in the program as determined by DMAS. Such action precludes further payment by DMAS for services provided for individuals subsequent to the date specified in the termination notice.

G. Appeals of adverse actions. A provider shall have the right to appeal adverse action taken by DMAS or its agent or DBHDS' decisions regarding the Medicaid IFDDS waiver. Provider appeals shall be considered pursuant to 12VAC30-10-1000 and 12VAC30-20-500 through 12VAC30-20-560.

H. Termination of a provider participation agreement upon conviction of a felony. Section 32.1-325 D 2 of the Code of Virginia mandates that "any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states or Washington, D.C., must, within 30 days, notify the Medicaid Program of this conviction and relinquish its provider agreement. In addition, termination of a provider participation agreement will occur as may be required for federal financial participation.

I. Case manager's responsibility for the Medicaid Long Term Care Communication Form (DMAS-225). It is the responsibility of the case manager to notify DMAS, DBHDS, and DSS, in writing, when any of the following circumstances occur:

1. Home and community-based waiver services are implemented.

2. An individual dies.

3. An individual is discharged or terminated from services.

4. Any other circumstances (including hospitalization) that cause home and community-based waiver services to cease or be interrupted for more than 30 calendar days.

5. A selection by the individual or his family/caregiver, as appropriate, of a different case management provider.

J. Changes or termination of care. It is the DBHDS staff's responsibility to authorize any changes to supporting documentation of an individual's plan of care based on the recommendations of the case manager. Waiver service providers are responsible for modifying the supporting documentation with the involvement of the individual or his family/caregiver, as appropriate. The provider shall submit the supporting documentation to the case manager any time there is a change in the individual's condition or circumstances that may warrant a change in the amount or type of service rendered. The case manager shall review the need for a change and shall sign the supporting documentation if he agrees to the changes. The case manager shall submit the revised supporting documentation to the DBHDS staff to receive approval for that change. DMAS or its agent or DBHDS has the final authority to approve or deny the requested change to individual's supporting documentation. DBHDS shall notify the individual or his family/caregiver, as appropriate, in writing of the right to appeal the decision or decisions to reduce, terminate, suspend, or deny services pursuant to DMAS client appeals regulations, 12VAC30-110, Eligibility and Appeals.

1. Nonemergency termination of home and community-based waiver services by the participating provider. The participating provider shall give the individual, his family/caregiver, as appropriate, and case manager 10 calendar days' written notification of the intent to terminate services. The notification letter shall provide the reasons for and effective date of the termination. The effective date of services termination shall be at least 10 calendar days from the date of the termination notification letter.

2. Emergency termination of home and community-based waiver services by the participating provider. In an emergency situation when the health and safety of the individual or provider is endangered, the case manager and DBHDS must be notified prior to termination. The 10-day written notification period shall not be required. When appropriate, the local DSS adult protective services or child protective services agency must be notified immediately. DBHDS Offices of Licensing and Human Rights must also be notified as required under the provider's license.

3. The DMAS termination of eligibility to receive home and community-based waiver services. DMAS shall have the ultimate responsibility for assuring appropriate placement of the individual in home and community-based waiver services and the authority to terminate such services to the individual for the following reasons:

a. The home and community-based waiver service is not the critical alternative to prevent or delay institutional (ICF/IID) placement;

b. The individual no longer meets the institutional level of care criteria;

c. The individual's environment does not provide for his health, safety, and welfare; or

d. An appropriate and cost-effective plan of care cannot be developed.

4. In the case of termination of home and community-based waiver services by DMAS staff:

a. Individuals shall be notified of their appeal rights by DMAS pursuant to 12VAC30-110.

b. Individuals identified by the case manager who no longer meet the level of care criteria or for whom home and community-based waiver services are no longer appropriate must be referred by the case manager to DMAS for review.

12VAC30-120-750
Article 2
Covered Services and Limitations and Related Provider Requirements

12VAC30-120-750. In-home residential support services.

A. Service description. In-home residential support services shall be based primarily in the individual's home. The service shall be designed to enable individuals enrolled in the IFDDS Waiver to be maintained in their homes and shall include: (i) training in or engagement and interaction with functional skills and appropriate behavior related to an individual's health and safety, personal care, activities of daily living and use of community resources; (ii) assistance with medication management and monitoring the individual's health, nutrition, and physical condition (iii) life skills training; (iv) cognitive rehabilitation; (v) assistance with personal care activities of daily living and use of community resources; and (vi) specialized supervision to ensure the individual's health and safety. Service providers shall be reimbursed only for the amount and type of in-home residential support services included in the individual's approved plan of care. In-home residential support services shall not be authorized in the plan of care unless the individual requires these services and these services exceed services provided by the family or other caregiver. Services are not provided by paid staff of the in-home residential services provider for a continuous 24-hour period.

1. This service must be provided on an individual-specific basis according to the plan of care, supporting documentation, and service setting requirements.

2. Individuals may have in-home residential, personal care, and respite care in their plans of care but cannot receive these services simultaneously.

3. Room and board and general supervision shall not be components of this service.

4. This service shall not be used solely to provide routine or emergency respite care for the parent or parents or other unpaid caregivers with whom the individual lives.

B. Criteria.

1. All individuals must meet the following criteria in order for Medicaid to reimburse providers for in-home residential support services. The individual must meet the eligibility requirements for this waiver service as defined. The individual shall have a demonstrated need for supports to be provided by staff who are paid by the in-home residential support provider.

2. A functional assessment must be conducted to evaluate each individual in his home environment and community settings.

3. Routine supervision/oversight of direct care staff. To provide additional assurance for the protection or preservation of an individual's health and safety, there are specific requirements for the supervision and

oversight of direct care staff providing in-home residential support as outlined below. For all in-home residential support services provided under a DBHDS license or Rehabilitation Accreditation Commission accreditation:

a. An employee of the provider, typically by position, must be formally designated as the supervisor of each direct care staff person providing in-home residential support services.

b. The supervisor must have and document at least one supervisory contact with each direct care staff person per month regarding service delivery and direct care staff performance.

c. The supervisor must observe each direct care staff person delivering services at least semi-annually. Staff performance, service delivery in accordance with the plan of care, and evaluation of and evidence of the individual's satisfaction with service delivery by direct care staff must be documented.

d. The supervisor must complete and document at least one monthly contact with the individual or his family/caregiver, as appropriate, regarding satisfaction with services delivered by each direct care staff person.

4. The in-home residential support supporting documentation must indicate the necessary amount and type of activities required by the individual, the schedule of in-home residential support services, the total number of hours per day, and the total number of hours per week of in-home residential support. A formal, written behavioral program is required to address behaviors, including self-injury, aggression or self-stimulation.

5. Medicaid reimbursement is available only for in-home residential support services provided when the individual is present and when a qualified provider is providing the services.

C. Service units and service limitations. In-home residential supports shall be reimbursed on an hourly basis for time the in-home residential support direct care staff is working directly with the individual. Total monthly billing cannot exceed the total hours authorized in the plan of care. The provider must maintain documentation of the date, times, the services that were provided, and specific circumstances preventing the provision of any scheduled services.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, each in-home residential support service provider must be licensed by DBHDS as a provider of supportive residential services or have Rehabilitation Accreditation Commission accreditation. The provider must also have training in the characteristics of individuals with related conditions and appropriate interventions, strategies, and support methods for individuals with related conditions and functional limitations.

1. For DBHDS licensed programs, a plan of care and ongoing documentation of service delivery must be consistent with licensing regulations.

2. Documentation must confirm attendance and the individual's amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results must be available in at least a daily note or a weekly summary. Data must be collected as described in the plan of care, analyzed, summarized, and then clearly addressed in the regular supporting documentation.

3. The supporting documentation must be reviewed by the provider with the individual, and this written review submitted to the case manager, at least semi-annually, with goals, objectives, and activities modified as appropriate.

4. Documentation must be maintained for routine supervision and oversight of all in-home residential support direct care staff. All significant contacts described in this section must be documented. A qualified developmental disabilities professional must provide supervision of direct service staff.

5. Documentation of supervision must be completed, signed by the staff person designated to perform the supervision and oversight, and include the following:

a. Date of contact or observation;

b. Person or persons contacted or observed;

c. A summary about direct care staff performance and service delivery for monthly contacts and semi-annual home visits;

d. Semi-annual observation documentation must also address individual satisfaction with service provision; and

e. Any action planned or taken to correct problems identified during supervision and oversight; and

f. Copy of the most recently completed DMAS-225 form. The provider must clearly document efforts to obtain the completed DMAS-225 form from the case manager.

12VAC30-120-752
12VAC30-120-752. Day support services.

A. Service description. Day support services shall include a variety of training, assistance, support, and specialized supervision offered in a setting (other than the home or individual residence), which allows peer interactions and community integration for the acquisition, retention, or improvement of self-help, socialization, and adaptive skills. When services are provided through alternative payment sources, the plan of care shall not authorize them as a waiver funded expenditure. Service providers are reimbursed only for the amount and type of day support services included in the individual's approved plan of care based on the setting, intensity, and duration of the service to be delivered. This does not include prevocational services.

B. Criteria. For day support services, the individual must demonstrate the need for functional training, assistance, and specialized supervision offered in settings other than the individual's own residence that allow an opportunity for being productive and contributing members of communities. In addition, day support services will be available for individuals who can benefit from supported employment services, but who need the services as an appropriate alternative or in addition to supported employment services.

1. A functional assessment must be conducted by the provider to evaluate each individual in his home environment and community settings.

2. Types and levels of day support. The amount and type of day support included in the individual's plan of care is determined according to the services required for that individual. There are two types of day support: center-based, which is provided primarily at one location/building, or noncenter-based, which is provided primarily in community settings. Both types of day support may be provided at either intensive or regular levels. To be authorized at the intensive level, the individual must meet at least one of the following criteria: (i) requires physical assistance to meet the basic personal care needs (toileting, feeding, etc.); (ii) has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish his service goals; or (iii) requires extensive constant supervision to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

C. Service units and service limitations. Day support cannot be regularly or temporarily provided in an individual's home or other residential setting (e.g., due to inclement weather or individual's illness) without prior written approval from DBHDS. Noncenter-based day support services must be separate and distinguishable from both in-home residential support services and personal care services. There must be separate supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. The supporting documentation must provide an estimate of the amount of day support required by the individual. The maximum is 780 units per plan of care year. If this service is used in combination with prevocational or supported employment services, the combined total units for these services can not exceed 780 units per plan of care year. Transportation shall not be billable as a day support service.

1. One unit shall be 1 to 3.99 hours of service a day.

2. Two units are 4 to 6.99 hours of service a day.

3. Three units are 7 or more hours of service a day.

Services shall normally be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, day support providers must meet the following requirements:

1. For DBHDS programs licensed as day support programs, the plan of care, supporting documentation, and ongoing documentation must be consistent with licensing regulations. For programs accredited by CARF as day support programs, there must be supporting documentation that contains, at a minimum, the following elements:

a. The individual's strengths, desired outcomes, required or desired supports and training needs;

b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All entities that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the individual's goals and objectives;

f. The estimated duration of the individual's needs for services; and

g. The entities responsible for the overall coordination and integration of the services specified in the plan of care.

2. Documentation must confirm the individual's attendance, the amount of the individual's time in services, and provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results must be available in at least a daily note or a weekly summary.

a. The provider must review the supporting documentation with the individual or his family/caregiver, as appropriate, and this written review submitted to the case manager at least semi-annually with goals, objectives, and activities modified as appropriate. For the annual review and anytime the supporting documentation is modified, the revised supporting documentation must be reviewed with the individual or his family/caregiver, as appropriate.

b. An attendance log or similar document must be maintained that indicates the date, type of services rendered, and the number of hours and units provided (including specific time frame).

c. Documentation must indicate whether the services were center-based or noncenter-based and regular or intensive level.

d. If intensive day support services are requested, in order to verify which of these criteria the individual met, documentation must be present in the individual's record to indicate the specific supports and the reasons they are needed. For reauthorization of intensive day support services, there must be clear documentation of the ongoing needs and associated staff supports.

e. In instances where day support staff are required to ride with the individual to and from day support, the day support staff time may be billed as day support, provided that the billing for this time does not exceed 25% of the total time spent in the day support activity for that day. Documentation must be maintained to verify that billing for day support staff coverage during transportation does not exceed 25% of the total time spent in the day support for that day.

f. Copy of the most recently completed DMAS-225 form. The provider must clearly document efforts to obtain the completed DMAS-122 DMAS-225 form from the case manager.

3. Supervision of direct service staff must be provided by a qualified developmental disabilities professional.

12VAC30-120-753
12VAC30-120-753. Prevocational services.

A. Service description. Prevocational services are services aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided for individuals who are not expected to be able to join the general work force without supports or to participate in a transitional, sheltered workshop within one year of beginning waiver services (excluding supported employment services or programs). Activities included in this service are not primarily directed at teaching specific job skills but at

underlying rehabilitative goals such as accepting supervision, attendance, task completion, problem solving, and safety.

B. Criteria. In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills that are aimed toward preparation for paid employment that may be offered in a variety of community settings.

C. Service units and service limitations. Billing is for one unit of service. This service is limited to 780 units per plan of care year. If this service is used in combination with day support or supported employment services, the combined total units for these services cannot exceed 780 units per plan of care year. Prevocational services may be provided in center or noncenter-based settings. There must be documentation about whether prevocational services are available in vocational rehabilitation agencies through § 110 of the Rehabilitation Act of 1973 or through the Individuals with Disabilities Education Act (IDEA). When services are provided through these sources to the individual, they will not be authorized as a waiver service. Prevocational services may only be provided when the individual's compensation is less than 50% of the minimum wage.

1. One unit shall be 1 to 3.99 hours of service a day.

2. Two units are 4 to 6.99 hours of service a day.

3. Three units are 7 or more hours of service a day.

Services shall normally be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, prevocational services providers must also meet the following requirements:

1. The prevocational services provider must be a vendor of extended employment services, long-term employment services, or supported employment services for DARS, or be licensed by DBHDS as a day support services provider. Providers must ensure and document that persons providing prevocational services have training in the characteristics of related conditions, appropriate interventions, training strategies, and support methods for individuals with related conditions and functional limitations.

2. Required documentation in the individual's record. The provider must maintain a record for each individual receiving prevocational services. At a minimum, the record must contain the following:

a. A functional assessment conducted by the provider to evaluate each individual in the prevocational environment and community settings.

b. A plan of care containing, at a minimum, the following elements (DBHDS licensing regulations require the following for plans of care):

(1) The individual's needs and preferences;

(2) Relevant psychological, behavioral, medical, rehabilitation, and nursing needs as indicated by the assessment;

(3) Individualized strategies including the intensity of services needed;

(4) A communication plan for individuals with communication barriers including language barriers; and

(5) The behavior treatment plan, if applicable.

3. The plan of care must be reviewed by the provider quarterly, annually, and more often as needed, modified as appropriate, and with written results of these reviews submitted to the case manager. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.

4. Documentation must confirm the individual's attendance, amount of time spent in services, type of services rendered, and provide specific information about the individual's response to various settings and supports as agreed to in the plan of care.

5. In instances where prevocational staff are required to ride with the individual to and from prevocational services, the prevocational staff time may be billed for prevocational services, provided that the billing for this time does not exceed 25% of the total time spent in prevocational services for that day. Documentation must be maintained to verify that billing for prevocational staff coverage during transportation does not exceed 25% of the total time spending the prevocational services for that day.

6. A copy of the most recently completed DMAS-225. The provider must clearly document efforts to obtain the completed DMAS-225 from the case manager.

12VAC30-120-754
12VAC30-120-754. Supported employment services.

A. Service description.

1. Supported employment services shall include training in specific skills related to paid employment and provision of ongoing or intermittent assistance or specialized training to enable an individual to maintain paid employment. Each supporting documentation must confirm whether supported employment services are available to the individual in vocational rehabilitation agencies through the Rehabilitation Act of 1973 or in special education services through 20 USC § 1401 of the Individuals with Disabilities Education Act (IDEA). Providers of these DARS and IDEA services cannot be reimbursed by Medicaid with the IFDDS Waiver funds. Waiver service providers are reimbursed only for the amount and type of habilitation services included in the individual's approved plan of care based on the intensity and duration of the service delivered. Reimbursement shall be limited to actual interventions by the provider of supported employment, not for the amount of time the recipient is in the supported employment environment.

2. Supported employment may be provided in one of two models. Individual supported employment is defined as intermittent support, usually provided one on one by a job coach for an individual in a supported employment position. Group supported employment is defined as continuous support provided by staff for eight or fewer individuals with disabilities in an enclave, work crew, or bench work/entrepreneurial model. The individual's assessment and plan of care must clearly reflect the individual's need for training and supports.

B. Criteria for receipt of services.

1. Only job development tasks that specifically include the individual are allowable job search activities under the IFDDS Waiver supported employment and only after determining this service is not available from DARS or IDEA.

2. In order to qualify for these services, the individual shall have a demonstrated need for training, specialized supervision, or assistance in paid employment and for whom competitive employment at or above the minimum wage is unlikely without this support and who, because of the disability, needs ongoing support, including supervision, training and transportation to perform in a work setting.

3. A functional assessment must be conducted to evaluate each individual in his work environment and related community settings.

4. The supporting documentation must document the amount of supported employment required by the individual. Service providers are reimbursed only for the amount and type of supported employment included in the plan of care based on the intensity and duration of the service delivered.

C. Service units and service limitations.

1. Supported employment for individual job placement is provided in one-hour units. This service is limited to 40 hours per week.

2. Group models of supported employment (enclaves, work crews, bench work, and entrepreneurial model of supported employment) will be billed according to the DMAS fee schedule.

3. Supported employment services are limited to 780 units per plan of care year. If used in combination with prevocational and day support services, the combined total units for these services cannot exceed 780 units, or its equivalent under the DMAS fee schedule, per plan of care year.

4. For the individual job placement model, reimbursement will be limited to actual documented interventions or collateral contacts by the provider, not the amount of time the individual is in the supported employment situation.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, supported employment providers must meet the following requirements:

1. Supported employment services shall be provided by agencies that are programs certified by the Rehabilitation Accreditation Commission to provide supported employment services or are DARS vendors of supported employment services.

2. Individual ineligibility for supported employment services through DARS or IDEA must be documented in the individual's record, as applicable. If the individual is ineligible to receive services through IDEA, documentation is required only for lack of DARS funding. Acceptable documentation would include a copy of a letter from DARS or the local school system or a record of a telephone call (name, date, person contacted) documented in the case manager's case notes, Consumer Profile/Social assessment or on the supported employment supporting documentation. Unless the individual's circumstances change, the original verification may be forwarded into the current record or repeated on the supporting documentation or revised Social Assessment on an annual basis.

3. Supporting documentation and ongoing documentation consistent with licensing regulations, if a DBHDS licensed program.

4. For non-DBHDS programs certified as supported employment programs, there must be supporting documentation that contains, at a minimum, the following elements:

a. The individual's strengths, desired outcomes, required/desired supports, and training needs;

b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. Services to be rendered and the frequency of services to accomplish the above goals and objectives;

d. All entities that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the individual's goals and objectives;

f. The estimated duration of the individual's needs for services; and

g. Entities responsible for the overall coordination and integration of the services specified in the plan of care.

5. Documentation must confirm the individual's attendance, the amount of time the individual spent in services, and must provide specific information regarding the individual's response to various settings and supports as agreed to in the supporting documentation objectives. Assessment results should be available in at least a daily note or weekly summary.

6. The provider must review the supporting documentation with the individual, and this written review submitted to the case manager, at least semi-annually, with goals, objectives, and activities modified as appropriate. For the annual review and in cases where the plan of care is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.

7. In instances where supported employment staff are required to ride with the individual to and from supported employment activities, the supported employment staff time may be billed as supported employment provided that the billing for this time does not exceed 25% of the total time spent in supported employment for that day. Documentation must be maintained to verify that billing supported employment staff coverage during transportation does not exceed 25% of the total time spent in supported employment for that day.

8. There must be a copy of the completed DMAS-225 form in the record. Providers must clearly document efforts to obtain the DMAS-225 form from the case manager.

12VAC30-120-756
12VAC30-120-756. Therapeutic consultation.

A. Service description. Therapeutic consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and service providers in supporting the individual. The specialty areas include the following: psychology, social work, occupational therapy, physical therapy, therapeutic recreation, rehabilitation, psychiatry, psychiatric clinical nursing, behavioral consultation, and speech/language therapy. These services may be provided, based on the individual's plan of care, for those individuals for whom specialized consultation is clinically necessary to enable their utilization of waiver services and who have additional challenges restricting their ability to function in the community. Therapeutic consultation services may be provided in the individual's home, in other appropriate community settings, and in conjunction with another waiver service. These services are intended to facilitate implementation of the individual's desired outcomes as identified in the individual's plan of care. Therapeutic consultation service providers are reimbursed according to the amount and type of service authorized in the plan of care based on an hourly fee for service.

B. Criteria. In order to qualify for these services, the individual shall have a demonstrated need for consultation in any of these services. Documented need must indicate that the plan of care cannot be implemented effectively and efficiently without such consultation from this service.

1. The individual's plan of care must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to family/caregivers and providers in order to implement the plan of care effectively.

2. Therapeutic consultation services may not include direct therapy provided to individuals receiving waiver services, or monitoring activities, and may not duplicate the activities of other services that are available to the individual through the State Plan of Medical Assistance.

C. Service units and service limitations. The unit of service shall equal one hour. The services must be explicitly detailed in the supporting documentation. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic consultation may not be billed solely for purposes of monitoring. Therapeutic consultations shall be available to individuals who are receiving at least one other waiver service and case management services.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, professionals rendering therapeutic consultation services, including behavior consultation services, shall meet all applicable state licensure or certification requirements. Persons providing rehabilitation consultation shall be rehabilitation engineers or certified rehabilitation specialists. Behavioral consultation may be performed by professionals based on the professional's knowledge, skills, and abilities as defined by DMAS.

1. Supporting documentation for therapeutic consultation. The following information is required in the supporting documentation:

a. Identifying information: individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for supporting documentation; and semi-annual review dates, if applicable;

b. Targeted objectives, time frames, and expected outcomes;

c. Specific consultation activities; and

d. A written support plan detailing the interventions or support strategies.

2. Monthly and contact notes shall include:

a. Summary of consultative activities for the month;

b. Dates, locations, and times of service delivery;

c. Supporting documentation objectives addressed;

d. Specific details of the activities conducted;

e. Services delivered as planned or modified; and

f. Effectiveness of the strategies and individuals' and caregivers' satisfaction with service.

3. Semi-annual reviews are required by the service provider if consultation extends three months or longer, are to be forwarded to the case manager, and must include:

a. Activities related to the therapeutic consultation supporting documentation;

b. Individual status and satisfaction with services; and

c. Consultation outcomes and effectiveness of support plan.

4. If consultation services extend less than three months, the provider must forward monthly contact notes or a summary of them to the case manager for the semi-annual review.

5. A written support plan, detailing the interventions and strategies for providers, family, or caregivers to use to better support the individual in the service.

6. A final disposition summary must be forwarded to the case manager within 30 calendar days following the end of this service and must include:

a. Strategies utilized;

b. Objectives met;

c. Unresolved issues; and

d. Consultant recommendations.

12VAC30-120-758
12VAC30-120-758. Environmental modifications.

A. Service description. Environmental modifications shall be defined as those physical adaptations to the individual's primary home or primary vehicle used by the individual, documented in the individual's plan of care, that are necessary to ensure the health, welfare, and safety of the individual, or that enable the individual to function with greater independence in the primary home and, without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repairs, central air conditioning, etc. Adaptations that add to the total square footage of the home shall be excluded from this benefit, except when necessary to complete an adaptation, as determined by DMAS or its designated agent. All services shall be provided in the individual's primary home in accordance with applicable state or local building codes. All modifications must be authorized by the service authorization agent. Modifications may be made to a vehicle if it is the primary vehicle being used by the individual. This service does not include the purchase of vehicles.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modifications of a remedial or medical benefit offered in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the State Plan for Medical Assistance or through another program. Environmental modifications shall be covered in the least expensive, most cost-effective manner. For enrollees in the Elderly or Disabled with Consumer Direction (EDCD) waiver (12VAC30-120-900 through 12VAC30-120-980), environmental modification services shall be available only to those EDCD enrollees who are also enrolled in the Money Follows the Person demonstration.

C. Service units and service limitations. Environmental modifications shall be available to individuals who are receiving case management services. To receive environmental modifications in the EDCD waiver, the individual must be receiving at least one other waiver service. To receive environmental modifications in the IFDDS waiver, the individual must be receiving case management services and at least one other waiver service. A maximum limit of $5,000 may be reimbursed per plan of care or calendar year, as appropriate to the waiver in which the individual is enrolled. Costs for environmental modifications shall not be carried over from year to year. All environmental modifications must be authorized by the service authorization agent prior to

billing. Modifications shall not be used to bring a substandard dwelling up to minimum habitation standards. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

Case managers or transition coordinators must, upon completion of each modification, meet face-to-face with the individual and his family/caregiver, as appropriate, to ensure that the modification is completed satisfactorily and is able to be used by the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-160, 12VAC30-120-730, 12VAC30-120-740, and 12VAC30-120-930, as appropriate, environmental modifications must be provided in accordance with all applicable state or local building codes by contractors who have a provider agreement with DMAS. Providers may not be spouses or parents of the individual. Modifications must be completed within the plan of care or the calendar year in which the modification was authorized, as appropriate to the waiver in which the individual is enrolled.

12VAC30-120-760
12VAC30-120-760. Skilled nursing services.

A. Service description. Skilled nursing services shall be provided for individuals with serious medical conditions and complex health care needs who require specific skilled nursing services that cannot be provided by non-nursing personnel. Skilled nursing may be provided in the home or other community setting. It may include consultation and training for other providers.

B. Criteria. In order to qualify for these services, the individual must have demonstrated complex health care needs that require specific skilled nursing services ordered by a physician and that cannot be otherwise accessed under the Title XIX State Plan for Medical Assistance. The individual's plan of care must stipulate that this service is necessary in order to prevent institutionalization and is not available under the State Plan for Medical Assistance.

C. Service units and service limitations. Skilled nursing services to be rendered by either registered or licensed practical nurses are provided in 15-minute units. Services must be explicitly detailed in the CSP and must be specifically ordered by a physician.

D. Provider requirements. Skilled nursing services shall be provided by a DMAS-enrolled home care organization provider or a home health provider, or licensed registered nurse or a licensed practical nurse under the supervision of a licensed registered nurse who is contracted or employed by a DBHDS licensed day support, respite, or residential provider. In addition to meeting the general conditions and requirements for home and community-based waiver participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, in order to be enrolled as a skilled nursing provider, the provider must:

1. If a home health agency, be certified by the VDH for Medicaid participation and have a current DMAS provider participation agreement for private duty nursing;

2. Demonstrate a prior successful health care delivery business or practice;

3. Operate from a business office; and

4. If community services boards or behavioral health authority employ or subcontract with and directly supervise a registered nurse (RN) or a licensed practical nurse (LPN) with a current and valid license issued by the Virginia State Board of Nursing, the RN or LPN must have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, or nursing home.

12VAC30-120-762
12VAC30-120-762. Assistive technology.

A. Service description. Assistive technology (AT) is available to recipients who are receiving at least one other waiver service and may be provided in a residential or nonresidential setting. AT is the specialized medical equipment and supplies, including those devices, controls, or appliances, specified in the plan of care, but not available under the State Plan for Medical Assistance, that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items.

B. Criteria. In order to qualify for these services, the individual must have a demonstrated need for equipment or modification for remedial or direct medical benefit primarily in an individual's primary home, primary vehicle used by the individual, community activity setting, or day program to specifically serve to improve the individual's personal functioning. This shall encompass those items not otherwise covered under the State Plan for Medical Assistance. Assistive technology shall be covered in the least expensive, most cost-effective manner. For enrollees in the Elderly or Disabled with Consumer Direction (EDCD) waiver (12VAC30-120-900 through 12VAC30-120-980), assistive technology services shall be available only to those EDCD enrollees who are also enrolled in the Money Follows the Person demonstration.

C. Service units and service limitations. AT is available to individuals receiving at least one other waiver service and may be provided in the individual's home or community setting. A maximum limit of $5,000 may be reimbursed per plan of care year or the calendar year, as appropriate to the waiver in which the individual is enrolled or calendar year, as appropriate to the waiver being received. Costs for assistive technology cannot be carried over from year to year and must be preauthorized each plan of care year. AT will not be approved for purposes of convenience of the caregiver/provider or restraint of the individual. An independent, professional consultation must be obtained from qualified professionals who are knowledgeable of that item for each AT request prior to approval by the prior authorization agent, and may include training on such AT by the qualified professional. All AT must be authorized by the service authorization agent prior to billing. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act, and the Rehabilitation Act.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-160, 12VAC30-120-730, 12VAC30-120-740, and 12VAC30-120-930, AT shall be provided by providers having a current provider participation agreement with DMAS as durable medical equipment and supply providers. Independent, professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, behavioral therapists, certified rehabilitation specialists, or rehabilitation engineers. Providers that supply AT for an individual may not perform assessment/consultation, write specifications, or inspect the AT for that individual. Providers of services may not be spouses or parents of the individual. AT must be delivered within the plan of care year, or within a year from the start date of the authorization, as appropriate to the waiver, in which the individual is enrolled.

12VAC30-120-764
12VAC30-120-764. Crisis stabilization services.

A. Service description. Crisis stabilization services involve direct interventions that provide temporary, intensive services and supports that avert emergency, psychiatric hospitalization or institutional placement of individuals who are experiencing serious psychiatric or behavioral problems that jeopardize their current community living situation. Crisis stabilization services shall include, as appropriate, neuropsychological, psychiatric, psychological and other functional assessments and stabilization techniques, medication management and monitoring, behavior assessment and support, and intensive care coordination with other agencies and providers. This service is designed to stabilize the individual and strengthen the current living situation so that the individual remains in the community during and beyond the crisis period.

These services shall be provided to:

1. Assist planning and delivery of services and supports to enable the individual to remain in the community;

2. Train family members, other care givers, and service providers in supports to maintain the individual in the community; and

3. Provide temporary crisis supervision to ensure the safety of the individual and others;.

B. Criteria.

1. In order to receive crisis stabilization services, the individual must meet at least one of the following criteria:

a. The individual is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;

b. The individual is experiencing extreme increase in emotional distress;

c. The individual needs continuous intervention to maintain stability; or

d. The individual is causing harm to self or others.

2. The individual must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/IID placement;

c. Disruption of community status (living arrangement, day placement, or school); or

d. Causing harm to self or others.

C. Service units and service limitations. Crisis stabilization services must be authorized following a documented face-to-face assessment conducted by a qualified developmental disabilities professional (QDDP).

1. The unit for each component of the service is one hour. Each service may be authorized in 15-day increments, but no more than 60 calendar days in a plan of care year may be used. The actual service units per episode shall be based on the documented clinical needs of the individuals being served. Extension of services beyond the 15-day limit per authorization must be authorized following a documented face-to-face reassessment conducted by a qualified professional as described in subsection D of this section.

2. Crisis stabilization services may be provided directly in the following settings (the following examples are not exclusive):

a. The home of an individual who lives with family or other primary caregiver or caregivers;

b. The home of an individual who lives independently or semi-independently to augment any current services and support;

c. A day program or setting to augment current services and supports; or

d. A respite care setting to augment current services and supports.

3. Crisis supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period. Crisis supervision must be provided one-on-one and face-to-face with the individual. Crisis supervision, if provided as a part of this service, shall be billed separately in hourly service units.

4. Crisis stabilization services shall not be used for continuous long-term care. Room and board and general supervision are not components of this service.

5. If appropriate, the assessment and any reassessments shall be conducted jointly with a licensed mental health professional or other appropriate professional or professionals.

D. Provider requirements. In addition to the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, the following crisis stabilization provider requirements apply:

1. Crisis stabilization services shall be provided by entities licensed by DBHDS as a provider of outpatient, residential, supportive in-home services, or day support services. The provider must employ or utilize qualified licensed mental health professionals or other qualified personnel competent to provide crisis stabilization and related activities for individuals with related conditions who require crisis stabilization services. Supervision of direct service staff must be provided by a QDDP. Crisis supervision providers must be licensed by DBHDS as providers of residential services, supportive in-home services, or day support services.

2. Crisis stabilization supporting documentation must be developed (or revised, in the case of a request for an extension) and submitted to the case manager for authorization within 72 hours of the face-to-face assessment or reassessment.

3. Documentation indicating the dates and times of crisis stabilization services, the amount and type of service provided, and specific information about the individual's response to the services and supports as agreed to in the supporting documentation must be recorded in the individual's record.

4. Documentation of provider qualifications must be maintained for review by DMAS staff. This service shall be designed to stabilize the individual and strengthen the current semi-independent living situation, or situation with family or other primary care givers, so the individual can be maintained during and beyond the crisis period.

12VAC30-120-766
12VAC30-120-766. Personal care and respite care services.

A. Service description. Services may be provided either through an agency-directed or consumer-directed model.

1. Personal care services means services offered to individuals in their homes and communities to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Personal care services substitute for the absence, loss, diminution, or impairment of a physical, behavioral, or cognitive function. This service shall provide care to individuals with activities of daily living (eating, drinking, personal hygiene, toileting, transferring and bowel/bladder control), instrumental activities of daily living (IADL), access to the community, monitoring of self-medication or other medical needs, and the monitoring of health status or physical condition. In order to receive personal care services, the individual must require assistance with their ADLs. When specified in the plan of care, personal care services may include assistance with IADL. Assistance with IADL must be essential to the health and welfare of the individual, rather than the individual's family/caregiver. An additional component to personal care is work or school-related personal care. This allows the personal care provider to provide assistance and supports for individuals in the workplace and for those individuals attending postsecondary educational institutions. Workplace or school supports through the IFDDS Waiver are not provided if they are services that should be provided by DARS, under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act, the Virginians with Disabilities Act, or § 504 of the Rehabilitation Act. Work-related personal care services cannot duplicate services provided under supported employment.

2. Respite care means services provided for unpaid caregivers of eligible individuals who are unable to care for themselves that are provided on an episodic or routine basis because of the absence of or need for relief of those unpaid persons who routinely provide the care.

B. Criteria.

1. In order to qualify for personal care services, the individual must demonstrate a need in activities of daily living, reminders to take medication, or other medical needs, or monitoring health status or physical condition.

2. In order to qualify for respite care, individuals must have an unpaid primary caregiver who requires temporary relief to avoid institutionalization of the individual.

3. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

1. The unit of service is one hour.

2. Effective July 1, 2011, respite care services are limited to a maximum of 480 hours per year. Individuals who are receiving services through both the agency-directed and consumer-directed models cannot exceed 480 hours per year combined.

3. Individuals may have personal care, respite care, and in-home residential support services in their plan of care but cannot receive in-home residential supports and personal care or respite care services at the same time.

4. Each individual receiving personal care services must have a back-up plan in case the personal care aide or consumer-directed (CD) employee does not show up for work as expected or terminates employment without prior notice.

5. Individuals must need assistance with ADLs in order to receive IADL care through personal care services.

6. Individuals shall be permitted to share personal care service hours with one other individual (receiving waiver services) who lives in the same home.

7. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated in accordance with 18VAC90-20-420 through 18VAC90-20-460.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, personal and respite care providers must meet the following provider requirements:

1. Services shall be provided by:

a. For the agency-directed model, a DMAS enrolled personal care/respite care provider or by a DBHDS-licensed residential supportive in-home provider. All personal care aides must pass an objective standardized test of knowledge, skills, and abilities approved by DBHDS and administered according to DBHDS' defined procedures.

Providers must demonstrate a prior successful health care delivery business and operate from a business office.

b. For the consumer-directed model, a service facilitation provider meeting the requirements found in 12VAC30-120-770.

2. For DBHDS-licensed providers, a residential supervisor shall provide ongoing supervision for all personal care aides. For DMAS-enrolled personal care/respite care providers, the provider must employ or subcontract with and directly supervise an RN who will provide ongoing supervision of all aides. The supervising RN must be currently licensed to practice in the Commonwealth and have at least two years of related clinical nursing experience that may include work in an acute care hospital, public health clinic, home health agency, ICF/IID, or nursing facility.

3. The RN supervisor or case manager/services facilitator must make a home visit to conduct an initial assessment prior to the start of care for all individuals requesting services. The RN supervisor or case manager/service facilitator must also perform any subsequent reassessments or changes to the supporting documentation. Under the consumer-directed model, the initial comprehensive visit is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation agencies, the new CD services facilitation provider must bill for a reassessment in lieu of a comprehensive visit.

4. The RN supervisor or case manager/services facilitator must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

a. For personal care the minimum frequency of these visits is every 30 to 90 calendar days depending on individual needs. For respite care offered on a routine basis, the minimum frequency of these visits is every 30 to 90 calendar days under the agency-directed model and every six months or upon the use of 240 respite care hours (whichever comes first) under the consumer-directed model.

b. Under the agency-directed model, when respite care services are not received on a routine basis, but are episodic in nature, the RN is not required to conduct a supervisory visit every 30 to 90 calendar days. Instead, the RN supervisor must conduct the initial home visit with the respite care aide immediately preceding the start of care and make a second home visit within the respite care period.

c. When respite care services are routine in nature and offered in conjunction with personal care, the 30-day to 90-day supervisory visit conducted for personal care may serve as the RN supervisor or case manager/service facilitator visit for respite care. However, the RN supervisor or case manager/services facilitator must document supervision of respite care separately. For this purpose, the same record can be used with a separate section for respite care documentation.

5. Under the agency-directed model, the supervisor shall identify any gaps in the aide's ability to provide services as identified in the individual's plan of care and provide training as indicated based on continuing evaluations of the aide's performance and the individual's needs.

6. The supervising RN or case manager/services facilitator must maintain current documentation. This may be done as a summary and must note:

a. Whether personal and respite care services continue to be appropriate;

b. Whether the supporting documentation is adequate to meet the individual's needs or if changes are indicated in the supporting documentation;

c. Any special tasks performed by the aide/CD employee and the aide's/CD employee's qualifications to perform these tasks;

d. Individual's satisfaction with the service;

e. Any hospitalization or change in the individual's medical condition or functioning status;

f. Other services received and their amount; and

g. The presence or absence of the aide in the home during the RN's visit.

7. Qualification of aides/CD employees. Each aide/CD employee must:

a. Be 18 years of age or older and possess a valid social security number;

b. For the agency-directed model, be able to read and write English to the degree necessary to perform the tasks required. For the consumer-directed model, possess basic math, reading and writing skills;

c. Have the required skills to perform services as specified in the individual's plan of care;

d. Not be the parents of individuals who are minors, or the individual's spouse. Payment will not be made for services furnished by other family members living under the same roof as the individual receiving services unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who are approved to be reimbursed for providing this service must meet the qualifications. In addition, under the consumer-directed model, family/caregivers acting as the employer on behalf of the individual may not also be the CD employee;

e. Additional aide requirements under the agency-directed model:

(1) Complete an appropriate aide training curriculum consistent with DMAS standards. Prior to assigning an aide to an individual, the provider must ensure that the aide has satisfactorily completed a training program consistent with DMAS standards. DMAS requirements may be met in any of the following ways:

(a) Registration as a certified nurse aide (DMAS-enrolled personal care/respite care providers);

(b) Graduation from an approved educational curriculum that offers certificates qualifying the student as a nursing assistant, geriatric assistant or home health aide (DMAS-enrolled personal care/respite care providers);

(c) Completion of provider-offered training that is consistent with the basic course outline approved by DMAS (DMAS-enrolled personal care/respite care providers);

(d) Completion and passing of the DBHDS standardized test (DBHDS-licensed providers);

(2) Have a satisfactory work record as evidenced by two references from prior job experiences, including no evidence of possible abuse, neglect, or exploitation of aged or incapacitated adults or children; and

(3) Be evaluated in his job performance by the supervisor.

f. Additional CD employee requirements under the consumer-directed model:

(1) Submit to a criminal records check and, if the individual is a minor, the child protective services registry. The employee will not be compensated for services provided to the individual if the records check verifies the employee has been convicted of crimes described in § 37.2-314 of the Code of Virginia or if the employee has a complaint confirmed by the DSS child protective services registry;

(2) Be willing to attend training at the request of the individual or his family/caregiver, as appropriate;

(3) Understand and agree to comply with the DMAS consumer-directed services requirements; and

(4) Receive an annual TB screening.

8. Provider inability to render services and substitution of aides (agency-directed model). When an aide is absent, the provider may either obtain another aide, obtain a substitute aide from another provider if the lapse in coverage is to be less than two weeks in duration, or transfer the individual's services to another provider.

9. Retention, hiring, and substitution of employees (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his family/caregiver, as appropriate, with a list of consumer-directed employees on the consumer-directed employee registry that may provide temporary assistance until the employee returns or the individual or his family/caregiver, as appropriate, is able to select and hire a new employee. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain an employee to provide consumer-directed services, the services facilitator must contact the case manager and DBHDS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid-funded agency-directed personal care or respite care services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

10. Required documentation in individuals' records. The provider must maintain all records of each individual receiving services. Under the agency-directed model, these records must be separated from those of other nonwaiver services, such as home health services. At a minimum these records must contain:

a. The most recently updated plan of care and supporting documentation, all provider documentation, and all DMAS-225 forms;

b. Initial assessment by the RN supervisory nurse or case manager/services facilitator completed prior to or on the date services are initiated, subsequent reassessments, and changes to the supporting documentation by the RN supervisory nurse or case manager/services facilitator;

c. Nurses' or case manager/services facilitator summarizing notes recorded and dated during any contacts with the aide or CD employee and during supervisory visits to the individual's home;

d. All correspondence to the individual, to DBHDS, and to DMAS;

e. Contacts made with family, physicians, DBHDS, DMAS, formal and informal service providers, and all professionals concerning the individual;

f. Under the agency-directed model, all aide records. The aide record must contain:

(1) The specific services delivered to the individual by the aide and the individual's responses;

(2) The aide's arrival and departure times;

(3) The aide's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered;

(4) The aide's and individual's weekly signatures to verify that services during that week have been rendered.;

(5) Signatures, times, and dates; these signatures, times, and dates shall not be placed on the aide record prior to the last date of the week that the services are delivered; and

(6) Copies of all aide records; these records shall be subject to review by state and federal Medicaid representatives.

g. Additional documentation requirements under the consumer-directed model:

(1) All management training provided to the individuals or their family caregivers, as appropriate, including responsibility for the accuracy of the timesheets.

(2) All documents signed by the individual or his family/caregivers, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-770
12VAC30-120-770. Consumer-directed model of service delivery.

A. Criteria.

1. The IFDDS Waiver has three services, companion, personal care, and respite services, that may be provided through a consumer-directed model.

2. Individuals who are eligible for consumer-directed services must have the capability to hire, train, and fire their consumer-directed employees and supervise the employee's work performance. If an individual is unable to direct his own care or is younger than 18 years of age, a family/caregiver may serve as the employer on behalf of the individual.

3. Responsibilities as employer. The individual, or if the individual is unable, then a family/caregiver, is the employer in this service and is responsible for hiring, training, supervising, and firing employees. Specific duties include checking references of employees, determining that employees meet basic qualifications, training employees, supervising the employees' performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. The individual or his family/caregiver, as appropriate, must have an emergency back-up plan in case the employee does not show up for work.

4. DMAS shall contract for the services of a fiscal agent for consumer-directed personal care, companion, and respite care services. The fiscal agent will be paid by DMAS to perform certain tasks as an agent for the individual/employer who is receiving consumer-directed services. The fiscal agent will handle responsibilities for the individual for employment taxes. The fiscal agent will seek and obtain all necessary authorizations and approvals of the Internal Revenue Services in order to fulfill all of these duties.

5. Individuals choosing consumer-directed services must receive support from a CD services facilitator. Services facilitators assist the individual or his family/caregiver, as appropriate, as they become employers for consumer-directed services. This function includes providing the individual or his family/caregiver, as appropriate, with management training, review and explanation of the Employee Management Manual, and routine visits to monitor the employment process. The CD services facilitator assists the individual/employer with employer issues as they arise. The services facilitator meeting the stated qualifications may also complete the assessments, reassessments, and related supporting documentation necessary for consumer-directed services if the individual or his family/caregiver, as appropriate, chooses for the CD services facilitator to perform these tasks rather than the case manager. Services facilitation services are provided on an as-needed basis as determined by the individual, family/caregiver, and CD services facilitator. This must be documented in the supporting documentation for consumer-directed services and the services facilitation provider bills accordingly. If an individual enrolled in consumer-directed services has a lapse in consumer-directed services for more than 60 consecutive calendar days, the case manager shall notify DBHDS so that consumer-directed services may be discontinued and the option given to change to agency-directed services.

B. Provider qualifications. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, services facilitators providers must meet the following qualifications:

1. To be enrolled as a Medicaid CD services facilitation provider and maintain provider status, the CD services facilitation provider must operate from a business office and have sufficient qualified staff who will function as CD services facilitators to perform the service facilitation and support activities as required. It is preferred that the employee of the CD services facilitation provider possess a minimum of an undergraduate degree in a human services field or be a registered nurse currently licensed to practice in the Commonwealth. In addition, it is preferable that the CD services facilitator has two years of satisfactory experience in the human services field working with individuals with related conditions.

2. The CD services facilitator must possess a combination of work experience and relevant education that indicates possession of the following knowledge, skills, and abilities. Such knowledge, skills, and abilities must be documented on the application form, found in supporting documentation, or be observed during the job interview. Observations during the interview must be documented. The knowledge, skills, and abilities include:

a. Knowledge of:

(1) Various long-term care program requirements, including nursing home, ICF/IID, and assisted living facility placement criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal care services;

(2) DMAS consumer-directed services requirements, and the administrative duties for which the individual will be responsible;

(3) Interviewing techniques;

(4) The individual's right to make decisions about, direct the provisions of, and control his consumer-directed services, including hiring, training, managing, approving time sheets, and firing an employee;

(5) The principles of human behavior and interpersonal relationships; and

(6) General principles of record documentation.

(7) For CD services facilitators who also conduct assessments and reassessments, the following is also required. Knowledge of:

(a) Types of functional limitations and health problems that are common to different disability types and the aging process as well as strategies to reduce limitations and health problems;

(b) Physical assistance typically required by people with developmental disabilities, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

(c) Equipment and environmental modifications commonly used and required by people with developmental disabilities that reduces the need for human help and improves safety; and

(d) Conducting assessments (including environmental, psychosocial, health, and functional factors) and their uses in care planning.

b. Skills in:

(1) Negotiating with individuals or their family/caregivers, as appropriate, and service providers;

(2) Observing, recording, and reporting behaviors;

(3) Identifying, developing, or providing services to persons with developmental disabilities; and

(4) Identifying services within the established services system to meet the individual's needs.

c. Abilities to:

(1) Report findings of the assessment or onsite visit, either in writing or an alternative format for persons who have visual impairments;

(2) Demonstrate a positive regard for individuals and their families;

(3) Be persistent and remain objective;

(4) Work independently, performing position duties under general supervision;

(5) Communicate effectively, orally and in writing;

(6) Develop a rapport and communicate with different types of persons from diverse cultural backgrounds; and

(7) Interview.

3. If the CD services facilitator is not an RN, the CD services facilitator must inform the primary health care provider that services are being provided and request skilled nursing or other consultation as needed.

4. Initiation of services and service monitoring.

a. If the services facilitator has responsibility for individual assessments and reassessments, these must be conducted as specified in 12VAC30-120-766 and 12VAC30-120-776.

b. Management training.

(1) The CD services facilitation provider must make an initial visit with the individual or his family/caregiver, as appropriate, to provide management training. The initial management training is done only once upon the individual's entry into the service. If an individual served under the waiver changes CD services facilitation providers, the new CD services facilitator must bill for a regular management training in lieu of initial management training.

(2) After the initial visit, two routine visits must occur within 60 days of the initiation of care or the initial visit to monitor the employment process.

(3) For personal care services, the CD services facilitation provider will continue to monitor on an as needed basis, not to exceed a maximum of one routine visit every 30 calendar days but no less than the minimum of one routine visit every 90 calendar days per individual. After the initial visit, the CD services facilitator will periodically review the utilization of companion services at a minimum of every six months and for respite services, either every six months or upon the use of 300 respite care hours, whichever comes first.

5. The CD services facilitator must be available to the individual or his family/caregiver, as appropriate, by telephone during normal business hours, have voice mail capability, and return phone calls within 24 hours or have an approved back-up CD services facilitator.

6. The CD services fiscal contractor for DMAS must submit a criminal record check within 15 calendar days of employment pertaining to the consumer-directed employees on behalf of the individual or family/caregiver and report findings of the criminal record check to the individual or his family/caregiver, as appropriate.

7. The CD services facilitator shall verify bi-weekly timesheets signed by the individual or his family caregiver, as appropriate, and the employee to ensure that the number of plan of care approved hours are not exceeded. If discrepancies are identified, the CD services facilitator must contact the individual to resolve discrepancies and must notify the fiscal agent. If an individual is consistently being identified as having discrepancies in his timesheets, the CD services facilitator must contact the case manager to resolve the situation.

8. Consumer-directed employee registry. The CD services facilitator must maintain a consumer-directed employee registry, updated on an ongoing basis.

9. Required documentation in individuals' records. CD services facilitators responsible for individual assessment and reassessment must maintain records as described in 12VAC30-120-766 and 12VAC30-120-776. For CD services facilitators conducting management training, the following documentation is required in the individual's record:

a. All copies of the plan of care, all supporting documentation related to consumer-directed services, and all DMAS-225 forms.

b. CD services facilitator's notes recorded and dated at the time of service delivery.

c. All correspondence to the individual, to others concerning the individual, and to DMAS and DBHDS.

d. All training provided to the consumer-directed employees on behalf of the individual or his family/caregiver, as appropriate.

e. All management training provided to the individuals or his family/caregivers, as appropriate, including the responsibility for the accuracy of the timesheets.

f. All documents signed by the individual or his family/caregiver, as appropriate, that acknowledge the responsibilities of the services.

12VAC30-120-772
12VAC30-120-772. Family/caregiver training.

A. Service description. Family or caregiver training is a service that provides training and counseling services to families or caregivers of individuals receiving waiver services. For purposes of this service, "family" is defined as the unpaid people who live with or provide care to an individual served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include people who are employed to care for the individual. All family/caregiver training must be included in the individual's written plan of care.

B. Criteria. The need for the training and the content of the training in order to assist family or caregivers with maintaining the individual at home must be documented in the individual's plan of care. The training must be necessary in order to improve the family or caregiver's ability to give care and support.

C. Service units and service limitations. Services will be billed hourly and must be prior authorized. Family, as defined in this section, may receive up to 80 hours of family/caregiver training per individual's plan of care year.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based waiver services participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, family/caregiver training providers must meet the following requirements:

1. Family/caregiver training must be provided on an individual basis, in small groups or through seminars and conferences provided by DMAS-enrolled family and caregiver training providers.

2. Family/caregiver training must be provided by providers with expertise in, experience in, or demonstrated knowledge of the training topic identified in the plan of care, and who work for an agency or organization that has a provider participation agreement with DMAS to provide these services. Providers must also have the appropriate licensure or certification as required for the specific professional field associated with the training area. Providers include the following: qualified staff of provider agencies; psychologists; licensed clinical social workers; and licensed professional counselors. Qualified staff of provider agencies must be licensed and include occupational therapists, physical therapists, speech/language pathologists, physicians, psychologists, licensed clinical social workers, licensed professional counselors, registered nurses, and special education teachers. Provision of services is monitored by the individual or his family/caregiver, as appropriate, or the case manager.

12VAC30-120-774
12VAC30-120-774. Personal emergency response system (PERS).

A. Service description. PERS is a service that monitors individual safety in the home and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. PERS may also include medication monitoring devices.

B. Criteria. PERS may be authorized when there is no one else is in the home who is competent or continuously available to call for help in an emergency.

C. Service units and service limitations.

1. A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, monitoring, and adjustments of the PERS. A unit of service is one-month rental price set by DMAS. The one-time installation of the unit includes installation, account activation, individual and caregiver instruction, and removal of PERS equipment.

2. PERS services must be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device must be waterproof, automatically transmit to the response center an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

3. PERS cannot be used as a substitute for providing adequate supervision of the individual.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, providers must also meet the following requirements:

1. A PERS provider is a certified home health or personal care agency, a durable medical equipment provider, a hospital, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring.

2. The PERS provider must provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from an individual's PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; of determining whether an emergency exists; and of notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

3. A PERS provider must comply with all applicable Virginia statutes, all applicable regulations of DMAS, and all other governmental agencies having jurisdiction over the services to be performed.

4. The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication-monitoring unit while the original equipment is being repaired.

5. The PERS provider must properly install all PERS equipment into the functioning telephone line of an individual receiving PERS and must furnish all supplies necessary to ensure that the system is installed and working properly.

6. The PERS installation includes local seize line circuitry, which guarantees that the unit will have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

7. A PERS provider must maintain all installed PERS equipment in proper working order.

8. A PERS provider must maintain a data record for each individual receiving PERS at no additional cost to DMAS. The record must document all of the following:

a. Delivery date and installation date of the PERS;

b. The signature of the individual or his family/caregiver, as appropriate, verifying receipt of PERS device;

c. Verification by a test that the PERS device is operational, monthly or more frequently as needed;

d. Updated and current individual responder and contact information, as provided by the individual or the individual's care provider, or case manager; and

e. A case log documenting the individual's utilization of the system and contacts and communications with the individual or his family/caregiver, as appropriate, case manager, or responder.

9. The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

10. Standards for PERS equipment. All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be automatically reset by the response center after each activation ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

11. A PERS provider must furnish education, data, and ongoing assistance to DBHDS and case managers to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and must instruct the individual, his family/caregiver, as appropriate, and responders in the use of the PERS service.

12. The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who have visual or hearing impairments or physical disabilities. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

13. Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from multiple individuals' PERS equipment. The monitoring agency's equipment must include the following:

a. A primary receiver and a back-up receiver, which must be independent and interchangeable;

b. A back-up information retrieval system;

c. A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

d. A back-up power supply;

e. A separate telephone service;

f. A toll free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

g. A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

14. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and recordkeeping and reporting procedures.

15. The PERS provider shall document and furnish within 30 calendar days of the action taken a written report to the case manager for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or activations made in error.

16. The PERS provider is prohibited from performing any type of direct marketing activities.

12VAC30-120-776
12VAC30-120-776. Companion services.

A. Service description. Companion services is a covered service when its purpose is to supervise or monitor those individuals who require the physical presence of an aide to ensure their safety during times when no other supportive people are available. This service may be provided either through an agency-directed or a consumer-directed model.

B. Criteria.

1. The inclusion of companion services in the plan of care is appropriate only when the individual cannot be left alone at any time due to mental or severe physical incapacitation. This includes individuals who cannot use a phone to call for help due to a physical or neurological disability. Individuals may receive companion services due to their inability to call for help if PERS is not appropriate for them.

2. Individuals having a current, uncontrolled medical condition making them unable to call for help during a rapid deterioration may be approved for companion services if there is documentation that the individual has had recurring attacks during the two-month period prior to the authorization of companion services. Companion services shall not be covered if required only because the individual does not have a telephone in the home or because the individual does not speak English.

3. There must be a clear and present danger to the individual as a result of being left unsupervised. Companion services cannot be authorized for individuals whose only need for companion services is for assistance exiting the home in the event of an emergency.

4. Individuals choosing the consumer-directed option must receive support from a CD services facilitator and meet requirements for consumer direction as described in 12VAC30-120-770.

C. Service units and service limitations.

1. The amount of companion service time included in the plan of care must be no more than is necessary to prevent the physical deterioration or injury to the individual. In no event may the amount of time relegated solely to companion service on the plan of care exceed eight hours per day.

2. A companion cannot provide supervision to individuals on ventilators, requiring continuous tube feedings, or requiring suctioning of their airways.

3. Companion services will be authorized for family members to sleep either during the day or during the night when the individual cannot be left alone at any time due to the individual's severe agitation or physically wandering behavior. Companion services must be necessary to ensure the individual's safety if the individual cannot be left unsupervised due to health and safety concerns.

4. Companion services may be authorized when no one else is in the home is competent to call for help in an emergency.

D. Provider requirements. In addition to meeting the general conditions and requirements for home and community-based care participating providers as specified in 12VAC30-120-730 and 12VAC30-120-740, companion service providers must meet the following requirements:

1. Companion services providers shall include:

a. For the agency-directed model: companion providers include DBHDS-licensed residential services providers; DBHDS-licensed supportive, in-home residential service providers; DBHDS-licensed day support service providers; DBHDS-licensed respite service providers; and DMAS-enrolled personal care/respite care providers.

b. For the consumer-directed model: a services facilitator must meet the requirements found in 12VAC30-120-770.

2. Companion qualifications. Companions must meet the following requirements:

a. Be at least 18 years of age;

b. Possess basic math skills and English reading and writing skills, to the degree necessary to perform the tasks required;

c. Be capable of following a plan of care with minimal supervision;

d. Submit to a criminal history record check and if providing services to a minor, submit to a record check under the State's Child Protective Services Registry. The companion will not be compensated for services provided to the individual if the records check verifies the companion has been convicted of crimes described in § 37.2-416 of the Code of Virginia;

e. Possess a valid social security number; and

f. Have the required skills to perform services as specified in the individual's plan of care.

g. Additional CD employee requirements under the consumer-directed model:

(1) Be willing to attend training at the request of the individual or his family/caregiver, as appropriate;

(2) Understand and agree to comply with the DMAS consumer-directed services requirements; and

(3) Receive an annual TB screening.

3. Companions may not be the individual's spouse. Other family members living under the same roof as the individual being served may not provide companion services unless there is objective, written documentation as to why there are no other providers available to provide the services. Companion services shall not be provided by adult foster care/family care providers or any other paid caregivers.

4. Family members who are reimbursed to provide companion services must meet the companion qualifications.

5. For the agency-directed model, companions are employees of entities that enroll with DMAS to provide companion services. Providers are required to have a companion services supervisor to monitor companion services. The supervisor must be an LPN, or an RN, have a current license or certification to practice in the Commonwealth, and have at least one year of experience working with individuals with related conditions; or must have a bachelor's degree in a human services field and at least one year of experience working with individuals with related conditions.

6. Retention, hiring, and substitution of companions (consumer-directed model). Upon the individual's request, the CD services facilitator shall provide the individual or his family/caregiver, as appropriate, with a list of potential consumer-directed employees on the consumer-directed employee registry that may provide temporary assistance until the companion returns or the individual or his family/caregiver as, appropriate, is able to select and hire a new companion. If an individual or his family/caregiver, as appropriate, is consistently unable to hire and retain a companion to provide consumer-directed services, the CD services facilitator must contact the case manager and DBHDS to transfer the individual, at the choice of the individual or his family/caregiver, as appropriate, to a provider that provides Medicaid-funded agency-directed companion services. The CD services facilitator will make arrangements with the case manager to have the individual transferred.

7. The provider or case manager/services facilitator must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish a plan of care for the individual. Under the agency-directed model, the provider must provide follow-up home visits quarterly or as often as needed to monitor the provision of services. Under the consumer-directed model, the case manager/services facilitator will periodically review the utilization of companion services at a minimum of every six months or more often as needed. The individual must be reassessed for services every six months.

8. Required documentation. The provider or case manager/services facilitator must maintain a record of each individual receiving companion services. At a minimum these records must contain the following:

a. An initial assessment completed prior to or on the date services are initiated and subsequent reassessments and changes to the supporting documentation.

b. The supporting documentation must be reviewed by the provider or case manager/services facilitator quarterly under the agency-directed model, semiannually under the consumer-directed model, annually, and more often, as needed, modified as appropriate, and the written results of these reviews submitted to the case manager. For the annual review and in cases where the supporting documentation is modified, the plan of care must be reviewed with the individual or his family/caregiver, as appropriate.

c. All correspondence to the individual, family/caregiver, case manager, DBHDS, and DMAS.

d. Contacts made with family/caregiver, physicians, formal and informal service providers, and all professionals concerning the individual.

e. The companion services supervisor or case manager/service facilitator must document in the individual's record a summary note following significant contacts with the companion and quarterly or semiannual home visits with the individual. This summary must include the following at a minimum:

(1) Whether companion services continue to be appropriate;

(2) Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;

(3) The individual's satisfaction with the service; and

(4) The presence or absence of the companion during the visit.

f. A copy of the most recently completed DMAS-225 form. The provider must clearly document efforts to obtain the completed DMAS-225 form from the case manager.

g. Additional documentation requirements under the consumer-directed model:

(1) All training provided to the companion on behalf of the individual or his family/caregiver, as appropriate.

(2) All management training provided to the individual or his family/caregiver, as appropriate, including responsibility for the accuracy of the timesheets.

(3) All documents signed by the individual or his family/caregiver, as appropriate, that acknowledge the responsibilities of the services.

h. Under the agency-directed model, all companion records. The companion record must contain the following:

(1) The specific services delivered to the individual by the companion, dated the day of service delivery, and the individual's response;

(2) The companion's arrival and departure times;

(3) The companion's weekly comments or observations about the individual to include observations of the individual's physical and emotional condition, daily activities, and responses to services rendered; and

(4) The weekly signatures of the companion and the individual or his family/caregiver, as appropriate, recorded on the last day of service delivery for any given week to verify that companion services during that week have been rendered.

12VAC30-120-9998
FORMS (12VAC30-120)

Virginia Uniform Assessment Instrument (UAI) (1994)

Consent to Exchange Information, DMAS-20 (rev. 4/03)

Provider Aide/LPN Record Personal/Respite Care, DMAS-90 (rev. 12/02)

LPN Skilled Respite Record, DMAS-90A (eff. 7/05)

Personal Assistant/Companion Timesheet, DMAS-91 (rev. 8/03)

Questionnaire to Assess an Applicant's Ability to Independently Manage Personal Attendant Services in the CD-PAS Waiver or DD Waiver, DMAS-95 Addendum (eff. 8/00)

Medicaid Funded Long-Term Care Service Authorization Form, DMAS-96 (rev. 10/06)

Screening Team Plan of Care for Medicaid-Funded Long Term Care, DMAS-97 (rev. 12/02)

Provider Agency Plan of Care, DMAS-97A (rev. 9/02)

Consumer Directed Services Plan of Care, DMAS-97B (rev. 1/98)

Community-Based Care Recipient Assessment Report, DMAS-99 (rev. 4/03)

Consumer-Directed Personal Attendant Services Recipient Assessment Report, DMAS-99B (rev. 8/03)

MI/MR Level I Supplement for EDCD Waiver Applicants, DMAS-101A (rev. 10/04)

Assessment of Active Treatment Needs for Individuals with MI, MR, or RC Who Request Services under the Elder or Disabled with Consumer-Direction Waivers, DMAS-101B (rev. 10/04)

Technology Assisted Waiver Provider RN Initial Home Assessment, DMAS-116 (11/10)

Medicaid Long Term Care Communication Form, DMAS-225 (rev. 10/11)

Technology Assisted Waiver/EPSDT Nursing Services Provider Skills Checklist for Individuals Caring for Tracheostomized and/or Ventilator Assisted Children and Adults, DMAS-259

Home Health Certification and Plan of Care, CMS-485 (rev. 2/94)

IFDDS Waiver Level of Care Eligibility Form (eff. 5/07)

Request for Screening for Individual and Family Developmental Disabilities Support Waiver (DD Waiver), DMAS 305 (rev. 3/09)

DD Medicaid Waiver - Level of Functioning Survey Summary Sheet, DMAS-458 (undated)

Technology Assisted Waiver Adult Aide Plan of Care, DMAS 97 T (rev. 6/08)

Technology Assisted Waiver Supervisory Monthly Summary, DMAS 103 (rev. 4/08)

Technology Assisted Waiver Adult Referral, DMAS 108 (rev. 3/10)

Technology Assisted Waiver Pediatric Referral, DMAS 109 (rev. 3/10)